work away on the incorrect assumption that we are so different.

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DEAR SIRS

In the interview with Dr John Howells (*Psychiatric Bulletin*, September 1990, **14**, 513–521) Howells states that in family psychiatry "the principle is that an individual who becomes sick is an element in a sick family". In contrast he says that in conjoint family therapy "the principle is to use the family to get the identified patient well". He seems to be indicating therefore that family therapy is a technique for helping individuals get better.

I would respectively point out that this is a gross misunderstanding of family therapy. The essence of family therapy is that the conceptual focus is on the whole family system, and that individual behaviour is seen as arising from, and feeding back into the family system. Treatment is aimed at altering the whole system for the benefit of all members. The vast majority of family therapy literature in the last 20 years has emphasised these very points, which Howells seems to be claiming to belong specifically to family psychiatry.

It seems to me that there is really no difference between family psychiatry and family therapy in terms of the conceptual focus or the unit of intervention.

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DEAR SIRS

I can understand the reason for Dr Child's and Dr Lask's bewilderment. The first key lies in Dr Lask's phrase "family therapy literature in the last 20 years". There was a whole generation of literature in the UK prior to 1970 and virtually the whole of this was on family psychiatry (Chadwick, 1971). When I gave my Chairman's address to the Child Psychiatry Section in 1961 'The Nuclear Family as the Functional Unit in Psychiatry' (Howells, 1962), I defined family psychiatry as a clinical approach which took the family as the functional unit in clinical practice. This definition was elaborated in my 1963 book *Family Psychiatry* describing my ten years of work 1950–1960. Post 1970 came the influence of the American conjoint family therapy literature, begun originally by my old friend Nathan Ackerman; as I said, this movement used a family group to help an individual patient. The family systems approach of family psychiatry cross-fertilised conjoint family therapy and 'family therapy' was a term commonly adopted for that movement subsequently. So far so good.

In my interview there was insufficient time to point to still major differences between family psychiatry and family therapy. Firstly, family psychiatry is a term which denotes a way for the profession of psychiatrists to practise psychiatry with the family as patient. It aims to give the same level of care to the mental patient as any other patient. Thus a highly trained practitioner, a consultant, takes direct responsibility for the patient; it eschews the unethical practice of 'covering'. Secondly, it is concerned with family pathology (not other family anomalies). Thirdly, it is a wide psychiatric approach concerned with the theory of psychiatry, clinical organisation, experiential psycho-pathology, multi-dimensional structured family diagnosis and multiple family treatment procedures (including vector therapy). Family therapy concerned, as its title suggests, with therapy and the treatment of families in groups is only one of family psychiatry's general procedures, and only one of its treatment procedures. As Rubinstein (1977), an American family therapist, commented "the field of family therapy is to be considered a branch of the broader discipline of family psychiatry".

JOHN HOWELLS

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Membership of women psychiatrists' support groups

DEAR SIRS

The article 'A support group for women psychiatrists' (*Psychiatric Bulletin*, September 1990, **14**, 531–533) raises some interesting points. As a former trainee on the Royal Free rotation and one of the "new women" who were not invited to join the group, I am also aware of the impact this experience had upon us.

It was particularly difficult to be informed about the group and invited to a meeting, only to have it made clear later that we were not being asked to join, but merely to observe and perhaps to learn. In

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retrospect, I feel this episode probably reflected the ambivalence of the group regarding new members. At the time I remember being rather mystified and puzzled by what had happened. A further paper could be written regarding subsequent events . . .

The authors note their shared "feminist perspective" and their belief "that women often come to believe that they are second-class and entitled to less than men". Their obviously successful group experience may well have assisted their own efforts to demolish this myth. Unfortunately, although the group may have intended to present new female trainees with a helpful role model, I was left with a lingering doubt that perhaps, having been "viewed" by the membership, I had been rejected as unsuitable. Obviously, this personal reaction has many other components, but for women thinking of setting up their own training scheme support systems, it may perhaps be helpful to consider the implications of an 'open' or 'closed' membership earlier, rather than later?

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DEAR SIRS

We are very pleased to see the interest in our paper on support groups for women psychiatrists.

If any woman felt excluded by our group we can only apologise and assure her that this was not our intention. The decision to close the group was taken after long and painful deliberation. However, no-one was in fact invited to join and then denied admission. The only criteria for group membership were being female and associated with the rotation at the relevant time (1983–84). After we decided to close the group we hosted two social events for all the women on the rotation and in fact some of the newer women set up a second women's support group, through the Women's Therapy Centre. Dr Griffin's letter emphasises the desire of many psychiatrists for support and we would welcome further discussion through the *Bulletin* as to how this can best be provided.

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Referrals of depressed patients in a general hospital

DEAR SIRS

The article 'Out-patient referrals of major depression to psychiatrist in Central Liverpool' by Drs B. Green and M. A. El-Hihi (*Psychiatric Bulletin*, August 1990, **14**, 465–467) throws light on an interesting, although not much investigated, area of psychiatry.

We want to share our experiences of depressive patients in a psychiatric out-patient clinic of a general hospital from India. More than 50% of our OPD attendance consists of patients referred from other clinics of the hospital; the rest come directly or are brought by the relations. In an analysis of data over six months (November 1988 to April 1989), 140 patients suffering from depression were referred for psychiatric evaluation from various clinics of the hospital. Interestingly, 132 of them had come from the department of internal medicine. The psychiatric diagnosis included psychotic depression (12.1%), neurotic depression (84.3%), prolonged depressive reaction (1.4%) and depressive disorder not elsewhere classified (22%). An interesting finding was that physical symptoms like subjective weakness, pain in extremities, headache, backache, chest pain, palpitations and giddiness were the presenting complaints in more than 90% of the patients. This was probably why these patients first went to the physician and when they were not found to suffer from physical illness, a psychiatric opinion was sought. Only 10% of the group had an accompanying physical illness and these patients did not differ from the others significantly.

We perceive that those referrals from the physician who finally receive a psychiatric diagnosis can be divided into three sub-groups. The first sub-group is formed by the patients in whom no physical disorder is detected and the physician faces a diagnostic dilemma. The second sub-group consists of patients in whom psychological symptoms are detected by the physician himself. The last sub-group consists of patients with a diagnosable physical illness with accompanying psychiatric problems. Only 10% of the patients had a diagnosable physical illness and, as one expects a higher figure in such patients, it appears that often physicians prefer to treat the psychiatric problems of the patients with physical illness themselves. But when they find themselves in difficulty with the case, they seek a psychiatric referral. Hamilton (1989) also noted that patients with mild depression are frequently treated by the physicians themselves rather than being referred to the psychiatrist.

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